Hospital Letterhead

Hospital ABN 8.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

We have reviewed the medical services you have received for *(specify services or condition)* from *(date of admission)* through *(date of last day reviewed)* and have determined that further hospitalization paid under the Medicare program is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

We have advised your attending physician of the denial of further skilled nursing care. Upon receipt of this notice, the items and services which you receive will no longer be covered under the Medicare program. The care that you need now is not skilled nursing care, and Medicare does not pay for it.

You are financially liable for all costs of the care you receive, except for those services for which you are eligible under Part B, beginning on *(specify date)*.1/ You should discuss other arrangements with your attending physician for any further health care you may require.

This notice is not an official Medicare determination. The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)* and to make that determination.

- **If you disagree with our conclusion and want an immediate review:**

  Request **immediately**, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO at the address listed below.

- **If you do not request an immediate review:**

  You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.

- **QIO Review Results:**

The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization and will inform you of your reconsideration rights.

IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment of all services beginning on *(specify date)*.1/

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____

(*Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.*)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from _____*Name of Hospital*_____ at _____*Time*_____ on _____*Date*_____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

Signature of patient or authorized representative Time Date

cc: QIO
Attending Physician

October 2003 - Form CMS-10092-H.

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1/ Insert: the date of the day following receipt of the hospital notice.